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TUBERCULOSIS PUBLIC PRIVATE MIX DIRECTLY OBSERVED TREATMENT SHORT-COURSE: FACILITY-SUPPORT TRANSITION GUIDELINES

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ACRONYMS

AFB	Acid Fast Bacilli
ART	Anti-Retroviral Therapy
EQA	External Quality Assurance
FMoH	Federal Ministry of Health
M & E	Monitoring and Evaluation
MOU	Memorandum of Understanding
PEPFAR	President's Emergency Plan for AIDS Relief
PHSP	Private Health Sector Program
PPM-DOTS	Public Private Mix-Directly Observed Treatment Short-course
PPP	Public-private partnership
RHB	Regional Health Bureau
SNNP	Southern, Nations, Nationalities and Peoples
TB	Tuberculosis
TB/HIV	Tuberculosis and HIV Co-infection
THO	Town Health Office
USAID	United States Agency for International Development
WoHO	Woreda Health Office

1. BACKGROUND

1.1 INTRODUCTION

The Private Health Sector Program (PHSP) in Ethiopia is funded by the United States government's President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) to increase access to and demand for high-quality public health services in the private health sector through building sustainable public-private partnerships. PHSP is a follow-on program covering 2009-2014 to the previous USAID Private Sector Program (PSP), a project also implemented by Abt Associates, Inc., in Ethiopia from 2004-2009. PHSP supports the Federal Ministry of Health (FMoH) and Regional Health Bureaus (RHBs) in their commitment to help strengthen the private health sector's capacity to deliver essential public health services for HIV, sexually transmitted infections, family planning, malaria, and tuberculosis (TB) based on national guidelines and protocols.

The four implementation strategies of PHSP are:

- Increasing access to essential public health services through the private sector
- Strengthening public-private partnerships (PPPs)
- Ensuring quality of essential services in the private health sector
- Building awareness of major public health issues as well as demand for supportive services.

One of the major areas in which PHSP strengthens the private sector service delivery is the promotion of a Public-Private Mix - Directly Observed Treatment Short-course (PPM-DOTS) approach to TB control, a key strategy of the World Health Organization's STOP-TB Partnership. The FMoH initiated the PPM-DOTS program in Ethiopia in August 2006. With support from USAID and PSP, the FMoH also developed and launched the National PPM-DOTS Implementation Guidelines. This provided the foundation for private health facilities' involvement in provision of DOTS for TB treatment, which was originally limited to public sector health facilities.

Beginning in October 2006, PSP piloted the TB PPM-DOTS program in 20 private health facilities in Addis Ababa and the Oromia Region. The pilot was formally evaluated after a year, found to be effective, and was subsequently rolled out to additional facilities and regions. The program has since expanded to 232 PHSP-supported private health facilities in five regions (Amhara, Harrari, Oromia, Southern Nations, Nationalities and Peoples (SNNP), and Tigray Regions) and two city administrations (Addis Ababa and Dire Dawa), all providing standardized PPM-DOTS services for TB patients. In addition, PHSP-supported facilities also screen all TB patients for HIV in line with the national TB/HIV collaborative intervention strategy. The regional distribution of supported facilities is in Table 1 below:

TABLE 1: DISTRIBUTION OF PHSP-SUPPORTED TB PPM-DOTS PRIVATE SECTOR FACILITIES

Region	No. of PHSP-supported facilities
Addis Ababa City Administration	33
Amhara	66
Dire Dawa City Administrations	10
Harrari	4
Oromia	79
SNNP	27
Tigray	14

1.2 RATIONALE FOR A FACILITY-SUPPORT TRANSITION GUIDELINES

As PSP/PHSP has been providing technical and material support to private health facilities since 2006, currently there are facilities that have become capable of successfully providing quality TB DOTS and TB/HIV services on their own with only minimal support. Since public private partnerships (PPPs) are well established and most RHBs are taking ownership of the TB PPM-DOTS program, these facilities should be able to function sustainably without continued PHSP support. PHSP has set as a goal to graduate 20 such facilities by the end of the fourth year of the five year project. At the same time, there are also some PHSP-supported PPM-DOTS facilities that are underperforming despite ongoing follow-up and support and should be assessed for discontinuation of PHSP support.

PHSP has established criteria to determine which facilities to graduate from program support, which to continue to support with PHSP funds, and which to drop from the program to conserve and refocus project resources and continue delivering the best implementation value for money.

The objectives of these facility-support transition guidelines are:

- To provide criteria and procedures to identify and graduate PHSP-supported TB PPM-DOTS facilities to the public health care system whereby these facilities can continue to provide TB and TB/HIV services with little or no support from PHSP;
- To provide criteria and procedures to identify underperforming facilities that will not be improved by ongoing PHSP support and will be dropped from receiving program support.

2. PHSP STRATEGIES FOR TB PPM-DOTS SERVICES

PHSP's strategies for TB PPM DOTS include:

- Increasing access to quality services in the private facilities by increasing the number of TB DOTS-providing facilities and expanding geographic accessibility.
- Strengthening public-private partnerships to improve referral systems and access to quality public drugs and supplies for private facilities.
- Ensuring the quality of TB and TB/HIV services in the PHSP-supported facilities through joint supportive supervision, mentoring, external quality assurance (EQA), trainings and clinical seminars, review meetings and job aids.
- Increasing awareness of and demand for TB and TB/HIV services in private facilities among the general population by addressing identified knowledge gaps through information, education and behavior change communication.

3. PHSP PUBLIC-PRIVATE PARTNERSHIPS

PHSP facilities PPP as the basic model to apply with the following partners playing a pivotal role in its implementation.

- **FMoH:** The FMoH provides overall leadership for the PPM program in Ethiopia, driving the policy changes required to enable the private sector providers to implement quality, standardized TB-DOTS services. The FMoH provided the original vision for piloting and rolling out the PPM-DOTS services, and the Ministry's clear direction has been instrumental in setting realistic targets for expansion of PPM-DOTS in the regions.
- **RHBs, regional laboratories, Zonal Health Departments (ZHDs), and local health offices:** Regional, zonal, and Woreda Health Offices (WoHO) integrate the PPM-DOTS clinics into their supply chain for TB drugs and laboratory reagents according to the agreement stipulated in the Memorandum of Understanding (MoU) between the private facilities and their RHB. The offices provide supportive supervision and EQA, include the private providers in regional TB review meetings, collect and compile TB and TB/HIV service statistics, and participate in treatment defaulter tracing to improve TB patient outcomes.
- **Public health facilities:** Public facilities, both hospitals and health centers, are part of the referral system to ensure continuum of TB and HIV care. Patients diagnosed with TB in a private clinic may need referral to a public facility closer to home for convenience of the daily visits during the intensive phase of DOTS. TB patients who test positive for HIV may also need to be referred to a public facility for antiretroviral treatment (ART) if the private clinic cannot provide ART.
- **Private clinics:** Private clinics commit to following national guidelines for TB and TB/HIV. They provide RHB-supplied TB drugs for free but are allowed to set their own fees for consultations and laboratory examinations. They report on program activities using FMoH standard registers and formats, reporting data to the national database; participate in meetings with their RHB and WoHO; and assist with treatment defaulter tracing.

4. TB PPM-DOTS PERFORMANCE UNDER PHSP

According to the FMoH 2010 National Annual TB Bulletin, 93 PHSP-supported PPM-DOTS facilities contributed to nine percent of TB case detection (all forms) in the country in the year 2009/10 (2002 Ethiopian Calendar), a substantial increase over the 2006 baseline figure of one percent.

Data analysis of a PHSP quarterly report from 173 PPM-DOTS facilities also confirms that the total number of cases diagnosed in the supported facilities in one year (2010/11) was 15,041, which is nearly 10% of the national TB case detection (all forms) in the same year. The average number of cases diagnosed in each of these facilities was 85 patients while the median was 36.5. The highest number of cases detected in a facility was 2,064, while the lowest number was zero. The first quartile was 12.75 while the second and third quartiles were 36.5 and 83.25 respectively. These data show that there are outliers on both sides of the curve. For purposes of transitioning, those facilities diagnosing below the first quartile are considered as underperforming compared to the majority of facilities (please refer to Annexes I and II for more details).

5. CRITERIA AND PROCEDURES FOR FACILITY TRANSITIONING

5.1 SELECTION CRITERIA TO GRADUATE FACILITIES FROM PHSP SUPPORT

To qualify for graduation status, each facility must meet ALL of the following criteria:

- Supported by PHSP for at least two years;
- Has reported activities as per the national TB program requirement and receives supplies based on accurate projected requirements and patient load (for TB drugs, AFB reagents);
- Has a good physical set-up for TB DOTS services, i.e., a separate TB clinic space conducive to TB infection control;
- Has good case detection and holding capacity, i.e., a minimum 36 cases per year (which is the median) and a TB treatment success rate of at least 85 percent;
- Has a good performance as documented by PHSP's supportive supervision and has been responsive to feedback given;
- Has a laboratory with the last two EQA assessments documented on site indicating that performance is meeting national TB standards;
- Good retention rate of trained staff, i.e., a minimum 70 percent per year;
- Good recordkeeping and reporting that are compliant with the national guidelines for completeness, correctness, and cleanliness.

Priority will be given to the first 20 pilot sites in Addis Ababa City Administration and Oromia Region as well as workplace clinics that have received USAID-provided project support since 2006.

5.2 PROCESS TO GRADUATE FACILITIES FROM PHSP SUPPORT

The following process will be followed:

1. Discuss selection criteria further with respective RHBs to ensure buy-in;
2. Select facilities to graduate in collaboration with respective RHBs, ZHDs and Woreda/Town Health Offices;
3. Confirm with the RHB that the owner of the facility has been notified about the transition process and other related procedures;
4. Phase I: Reduce PHSP supported mentoring and EQA frequency from the current quarterly basis to a biannual basis. However, data collection will continue as before. Training of health professionals, monitoring and evaluation, and supplies such as drugs and reagents, will be handled by the respective RHBs;
5. Phase II: After the transitioning process has completed one year, assess to determine when the final graduation date will occur.

5.3 SELECTION CRITERIA TO DISCONTINUE PHSP SUPPORT OF FACILITIES

If a facility meets the first two criteria below, this is considered sufficient to discontinue support to that facility. The third and fourth criteria will provide additional validation for this decision. The criteria are:

1. Facilities which have had only a minimum of one year of PHSP support;
2. Facilities which report detection or diagnosis of fewer than 10 patients per year, even with continuous support by PHSP and the Town Health Office (THO); exceptions will be made if the facility is part of a workplace and/or if the facility is the only PPM-DOTS facility in the town;
3. Facilities which have a recognized low commitment level, characterized by ongoing resistance to receiving feedback on areas of needed improvement;
4. Facilities that have poor EQA results and no improvement over three EQA rounds.

5.4 PROCESS TO DISCONTINUE FACILITIES FROM PHSP SUPPORT

The process to discontinue PHSP support are outlined below:

1. Discuss and reach consensus with respective RHBs on the cutoff point for support to a facility;
2. Discuss and agree with PPM-DOTS facilities on whether the criteria for discontinuing PHSP support have been met;
3. Identify facilities to be discontinued from PHSP support with their respective RHBs and THOs;
4. Arrange for all the drugs, reagents, and monitoring and evaluation materials provided by PHSP to be returned to the respective THOs;
5. Dissolve the MOU by informing the facility managers and discussing the reasons for discontinuation and reach mutual consensus;
6. Discontinue PHSP support on an agreed-upon cutoff date;
7. Continue to support patients on TB treatment when PHSP facility support is discontinued until they complete current treatment cycle..

ANNEX A: REGIONAL PPM-DOTS FACILITY PERFORMANCE

Region/City Administration	No. of facilities in 2010/11	No. of TB cases diagnosed in 2010/11	No. TB cases diagnosed treated in 2010/11	Remarks
Addis Ababa	24	1,467	1,210 (83%)	
Dire Dawa	6	299	128 (43%)	Started last year
Oromia	60	4,367	1,280 (29%)	
Amhara	58	7,957	1,009 (13%)	
SNNP	14	516	128 (25%)	
Tigray	8	352	160 (46%)	Started last year
Harari	3	83	23 (28%)	Started last year
Total	173	15,041	3,938 (26%)	

ANNEX B: FACILITY PERFORMANCE DISAGGREGATED BY REGION

Region	No. of facilities,2011	Total No. of cases diagnosed per year(2010/11)	Average No of pts. Diagnosed. Per year(201/12)	Minimum	1st quartile	2nd quartile (median)	3rd quartile	Maximum
Addis Ababa	24	1467	61	0	14	37	76.5	343
Oromia	60	4367	70	0	12	36	82	573
Amhara	58	7957	86	0	13	38	83	2064
SNNP	14	516	36	0	9	29	56	139
Tigray	8	352	44	0	10	29	54	121
Dire Dawa	6	299	49.8	13	26	40	79	111
Harrari	3	85	28	2	11	23	37	54
National	176	15,043	85	0	13	37	83	2,064